A Survey of County Jails in Tennessee:

Four Years Later

A Descriptive Study of Services to People with Mental Illness and Substance Abuse Problems

Submitted to the:
Tennessee Mental Health Planning and Policy Council
February, 2003

Sita Diehl, MSSW and Elizabeth Hiland, MSSW
Mental Health/Criminal Justice Training Program,
A Byrne Grant Project of the
Tennessee Department of Mental Health and Developmental Disabilities

Executive Summary

There are more than three times as many people with mental illness in the Tennessee county jails (17%) as in the general population (5%) (Kessler et al, 1999). Nationally almost a quarter (23.2%) of the jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of untreated mental illness (Ditton, 1999). This study, sponsored by the Tennessee Mental Health Planning and Planning Council, examines the number of county jail inmates with serious mental illness and substance abuse issues, services provided in the jails and in the community, and training of correctional personnel that interact with mentally ill inmates. The purpose is to determine what services and supports exist and what can be done through training and coordination to make better use of those resources.

The 2002 "Tennessee Survey of County Jails" questionnaire was modeled on a previous study sponsored by the TennCare Partners Roundtable. Questionnaires were mailed to individuals designated by the sheriffs with instructions to review the questions and collect information. Telephone interviews were conducted over a two-month period with 179 respondents including sheriffs, jail administrators, correctional medical personnel and others representing jail systems from all of the 95 counties in Tennessee.

At the time of the survey an estimated 2509 inmates were diagnosed with mental illness representing 16.7% of the total inmate population, a slight decrease from 1998 and comparable to national rates of mental illness in the jail and prison populations. One fifth (20%) of the total inmate population received psychiatric medication, 2% demonstrated suicidal thoughts, and 53% were estimated to have serious substance abuse problems.

More than two-thirds of the county jails offered mental health assessment, pastoral counseling and psychiatric medications. However, less than one quarter of the jails offered substance abuse counseling even though more than half of the inmates were thought to have serious substance use disorders.

The most common jail diversion and service linkage programs offered in the community included mobile crisis response teams, screening and evaluation, medication evaluation, and post-booking diversion to mental health agencies. However, the services that received the highest satisfaction ratings were only available to a few communities. Those services included mental health court, specially trained police, 24-hour crisis triage centers, criminal justice/mental health liaison personnel and pre-trial diversion services. Cost of psychiatric medication was a major concern to jail administrators, who employed various strategies to control expenditures. Correctional staff from three fourths of the jails attended training programs on mental health topics. Training was conducted by the Tennessee Corrections Institute, criminal justice/mental health liaisons and mental health center staff.

Recommendations concern provision of prevention and early intervention services by mental health and criminal justice personnel, establishing best practices in

more Tennessee communities and bringing mental health and substance abuse services to correctional facilities rather than transporting inmates to community agencies. Training programs should be developed and disseminated to mental health providers, criminal justice personnel, consumers and family members. The Criminal Justice/ Mental Health Task Force made recommendations in FY2000 that are still pertinent such as implementing standards of care for incarcerated persons with mental illness, using collective bargaining to control medication costs, suspending rather than disenrolling TennCare beneficiaries with serious mental illness who enter the jails, expediting TennCare benefits upon release, and establishing transportation alternatives to sheriffs' personnel when evaluating persons for civil commitment to Regional Mental Health Institutes.

Collaboration between the Tennessee criminal justice and mental health systems appears to be making headway. Previous efforts by the TennCare Partners Roundtable, the Criminal Justice/Mental Health Task Force and the Tennessee Mental Health Policy and Planning Council have illuminated the problem and established initiatives to resolve the problem of the criminalization of mental illness in Tennessee.

Table of Contents

Tables

Introduction

There are three times as many people with mental illness in Tennessee County jails (17%) as in the general population (5%) (Kessler et al, 1999) This disproportionate share creates a drain on criminal justice resources that do not have staff or resources to provide treatment. The mental health system is adversely affected because repeated incarceration of mental health clients interferes with treatment continuity and successful outcomes. Many of the issues in Tennessee reflect disturbing national trends.

This study, sponsored by the Tennessee Mental Health Policy and Planning Council, examines the number of county jail inmates with serious mental illness and substance abuse issues, services provided in the jails and in the community, and training of correctional personnel that interact with mentally ill inmates. The purpose is to determine what services and supports exist and what can be done through training and coordination to make better use of those resources. Recommendations are made for service improvements that will make best use of limited resources to catalyze better results for individuals with serious mental illness that become involved with the criminal justice system.

Need

Although an estimated 5% of the US population has serious mental illness, the US Department of Justice reported in 1999 that 16% of the population of US jails had a serious mental illness. This represents an increase from earlier studies estimating that 3-11% of the jail population had serious mental illness (Steadman, McCarty and Morrissey, 1989). The 1998 *Survey of County Jails in Tennessee* found that 19% of jail inmates were thought to have serious mental illness. In the current study 17% of total jail inmates were reported to have serious mental illness, but 74% of the jail systems reported an increase in numbers of mentally ill inmates over the last year.

Comparison of numbers of persons with serious mental illness housed in county jails versus state mental health institutes has led to the opinion that deinstitutionalization has caused the current criminalization of mental illness. However, the benefits of deinstitutionalization have been conclusively demonstrated over the past 35 years. Moving from a treatment system based on isolation and institutionalization to one based on community integration and recovery has resulted in increased quality of life for the vast majority of persons with mental illness and in decreased costs to the state. Effective treatment and rehabilitation models have been developed to assist even the most ill to recovery. Most people with mental illness are now living and working in the community and are indistinguishable from the general population.

Recovery and community integration are most likely to break down where people with serious mental illness do not have access to community mental health services.

According to the national Criminal Justice/ Mental Health Consensus Project (2002) common barriers to effective treatment include:

- People with psychotic symptoms experiencing fear and confusion about mental health services,
- Family reluctance to bring individuals for treatment to avoid public stigma,
- Inability to pay for the high cost of the most effective medications,
- Under funding of mental health services resulting in high caseloads, restrictive eligibility criteria and long waiting lists,
- Lack of housing options and housing support services,
- Marginalization of the most vulnerable to homelessness and lack of contact with formal services.

Because of these gaps in mental health treatment, people with mental illness increasingly come into contact with the police, the courts and the correctional system. Most criminal justice professionals encounter people with mental illness when they have decompensated due to lack of medication and treatment. Criminal justice personnel therefore receive the mistaken impression that most people with mental illness are violent or prone to cause a public nuisance.

Jails are not established to provide treatment and often do not have the resources to provide access to psychiatric treatment and appropriate medications for inmates with mental illness. Inmates who do not receive treatment act upon increasing symptoms and may fail to follow correctional rules, which extends the period of incarceration. Inmates may be released with a short supply of medication, very little money and few linkages with treatment providers or housing resources. The Bureau of Justice Statistics reported that over 70% of inmates with mental illness were arrested for minor incidents, but spent longer periods in jail than other persons arrested for similar offenses (Ditton, 1999).

Tennessee Background

Incarceration of persons with mental illness for minor crimes has been an ongoing concern across Tennessee (Fine, 1988). Studies were conducted in local areas such as Shelby County, (Zager,1990; Dupont, 1998), Davidson County (Janes, 1993) Davidson, Cheatham, Houston, Humphries and Stewart Counties (Hea et al, 1999).

In 1998, the TennCare Partners Roundtable conducted a statewide survey of county jails to assess the numbers of mentally ill persons being held in county jails and the mental health and substance abuse supports available to them while incarcerated. Results indicated that rates of incarceration of persons with mental illness (19%) were above national averages (16%) and that over half of persons incarcerated in jails had serious drug or alcohol problems. Slightly over one half of the jails reported programs diverting mentally ill persons to treatment and less than half had a procedure to link the mentally ill population to local mental health services after release from jail. Twenty-

five jail systems reported having a training program to deal with mentally ill inmates. Most of the training was conducted by the Tennessee Corrections Institute.

Based on concerns raised by the survey, a Criminal Justice Task Force was formed of mental health and criminal justice system stakeholders. Recommendations from the Task Force Report (2000) focused on mental health, criminal justice, training recommendations and systems changes (See Appendix A). Several of the recommendations were implemented such as boundary spanners, increased specialized interdisciplinary training, mental health court, increased housing options, and an ongoing Criminal Justice Advisory Committee.

A deepening state budget crisis in Tennessee, combined with increased enrollment in TennCare, has caused mental health services across the state to be increasingly stretched. Critical services for the most severely impaired individuals with mental illness such as mobile crisis intervention, medication management, and intensive case management are available across the state, but with increasing caseloads and longer wait times for services. Stakeholders in the mental health and criminal justice systems expressed concern that more people with serious mental illness are becoming incarcerated in county jails for lack of community services and supports, and because of lack of knowledge regarding effective procedures to access mental health and criminal justice resources.

The Criminal Justice Advisory Committee of the Tennessee Mental Health Planning and Policy Council commissioned the current survey to gather baseline data in preparation for development of a comprehensive set of training curricula for mental health and criminal justice personnel. Funded by a Byrne Formula grant from the federal Bureau of Justice, project goals are:

- To assess the current rates of incarceration and services available to persons with serious mental illness and substance use disorders, and
- To develop curricula and train-the-trainer processes for all sectors of the public mental health and criminal justice systems.

Tennessee Jail Survey

Methods

Questionnaire

The 2002 questionnaire was modeled on the 1998 study in an effort to track change over time. Based on a critique of the previous study (Lewyckyj, 1999), models of jail diversion and release procedures were described in more detail to give respondents a better idea of what was being asked. The current literature was reviewed to identify best practices in jail diversion, mental health services during incarceration, and release linkages. Because of grave concerns expressed by the Tennessee Sheriffs Association, a question was included regarding monthly psychiatric medication costs disbursed by county jails. In an effort to obtain a better response rate,

data regarding mental health and substance abuse status of inmates were collapsed into one group of the total inmate population versus the previous survey where status was requested for inmates incarcerated pre-adjudication, less than one year or more than one year. Diagnoses of serious mental illness were specified, as were common psychiatric medications. The questionnaire was field tested with a member of the Criminal Justice Advisory Committee who was employed in a correctional facility.

The resulting questionnaire was four pages in length and covered:

- screening and intake,
- services and resources offered by correctional facilities,
- cost of psychiatric medications,
- diversion services provided by law enforcement, mental health agencies and the courts,
- release service linkage resources,
- satisfaction with available resources,
- training for correctional personnel, and
- number of inmates with mental illness, substance abuse disorders and suicidal behavior at one point in time.

Data Collection

Sheriffs were asked to name a contact person for each county jail system. Questionnaires were mailed to those designated individuals with instructions to review the questions and prepare answers for a telephone interview. The project coordinator conducted telephone interviews from November 7 to December 19, 2002. Interview time ranged from approximately 20 minutes to one hour per jail system. No on-site reviews of jail census data were conducted.

Respondents

During interviews a total of 179 individuals actually responded to the various items, often more than one respondent per jail system. Types of respondents are shown in **Table 1**.

Table 1: Types of Respondents

Personnel Type	#	%
Jail Administrator	91	50.8
Other Jail Administrative Personnel	32	17.9
Nurse/ Nurse Practitioner/Mental Health Personnel	20	11.2
Sheriff	12	6.7
Criminal Justice/ Mental Health Liaison	10	5.6
Jail Medical Administrator	6	3.3
Jail Financial Officer	4	2.2
County Executive Personnel	3	1.7
Other	1	.6
Totals	179	100

Results

Interviews were conducted with county jail systems in each of the 95 counties of Tennessee. Portions of the questionnaire regarding services provided in jails, diversion services and release services were completed by 100% of the jail systems. Medication cost information was supplied by 79 (83.1%) of the jail systems with 25 (26.3%) giving exact figures and 54 (56.8%) providing estimates. Sections on correctional staff training were completed by 92 (96.8%) of the jail systems. Some information on the inmate population was supplied by all 95 jail systems with one day prevalence figures of inmates with mental illness and/or psychiatric medication provided by 88 (92.6%) jail systems, information regarding the number of inmates with substance abuse disorders provided by 85 (89.5%) and number of suicidal inmates provided by 91 (95.8%). Summary of results for each item are shown in Appendix C.

Incarceration Rates

At the time of the survey an estimated 2509 inmates were diagnosed with mental illness. When asked for their opinion whether the number of inmates with mental illness had increased or decreased in their facility over the past 12 months, respondents from seventy jail systems (73.7%) reported an increase. Some jail systems were able to furnish exact one-day prevalence figures on persons with psychiatric and substance abuse conditions while others provided estimates. Exact figures are compared with (estimated figures) as follows:

- 10.4% (22.7%) of the incarcerated individuals in Tennessee county jails were diagnosed with mental illness (see Appendix B, p.32 for list of diagnoses),
- 6% (15.1%) exhibited behaviors suggesting mental illness, but were not diagnosed,
- 15.6% (31.3%) were receiving psychiatric medications (see Appendix B for list of medications)
- 33.1% (61.5%) had a serious substance use disorder where drugs or alcohol were involved in the crime
- 1.9% (2.7%) had voiced suicidal thoughts or made suicidal gestures.

Estimated rates for all conditions were higher than exact figures. Rates from all reporting jail systems are illustrated in Table 2.

Figures from the current survey represent differences from 1998 when 67.5% of the jail systems reported an increase of inmates with mental illness over the past twelve months. Approximate rates of incarceration in the 1998 study are as follows:

- 18.9% inmates were diagnosed with mental illness, a total of 2923 individuals
- 5.6% were considered seriously mentally ill, but not diagnosed
- 18.2% were receiving psychiatric medications
- 48.7% were estimated to have a serious alcohol problem
- 17.1% were estimated to have a serious drug problem
- 2.4% were considered suicidal.

Caution should be used in making comparisons since data collection methods differed between studies. A comparison is illustrated in Table 3.

Table 2. Inmate Population

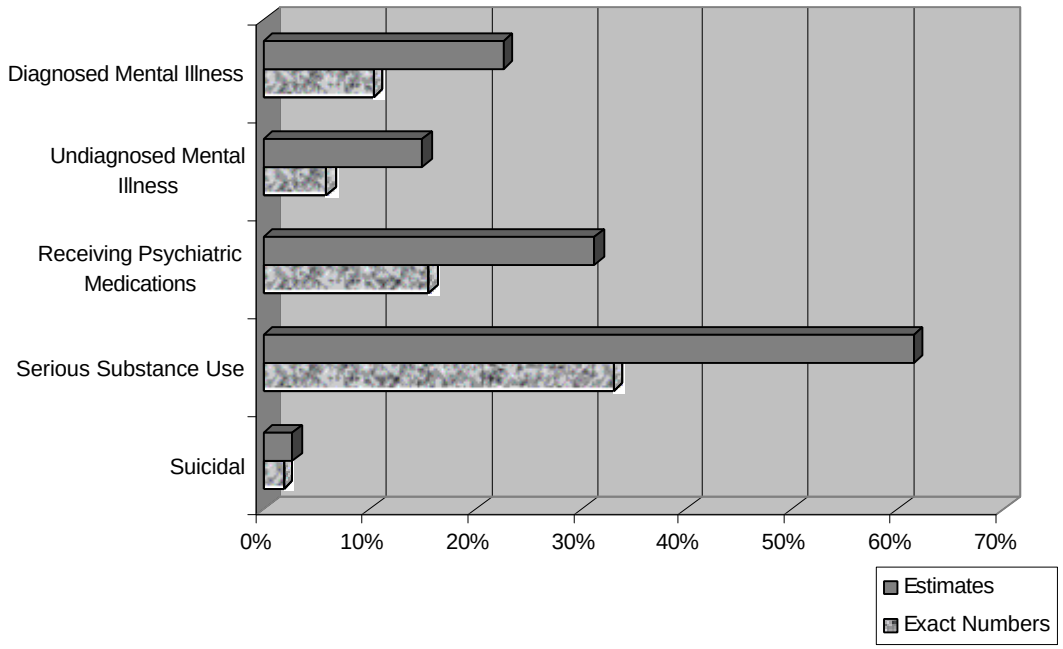
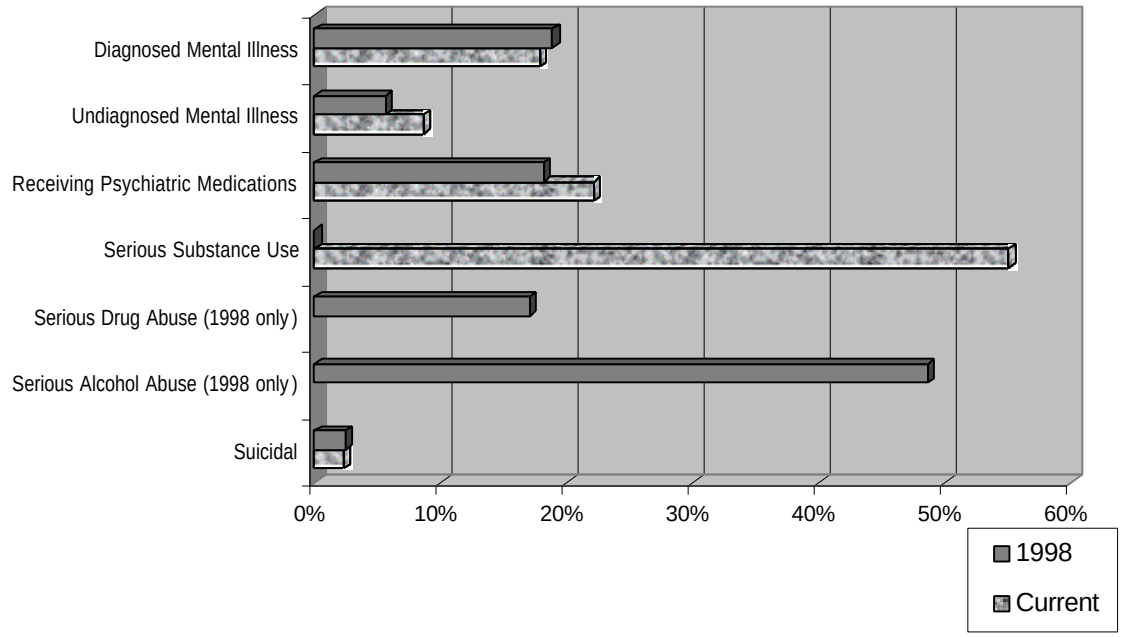


Table 3. Inmate Population, 1998 - 2002



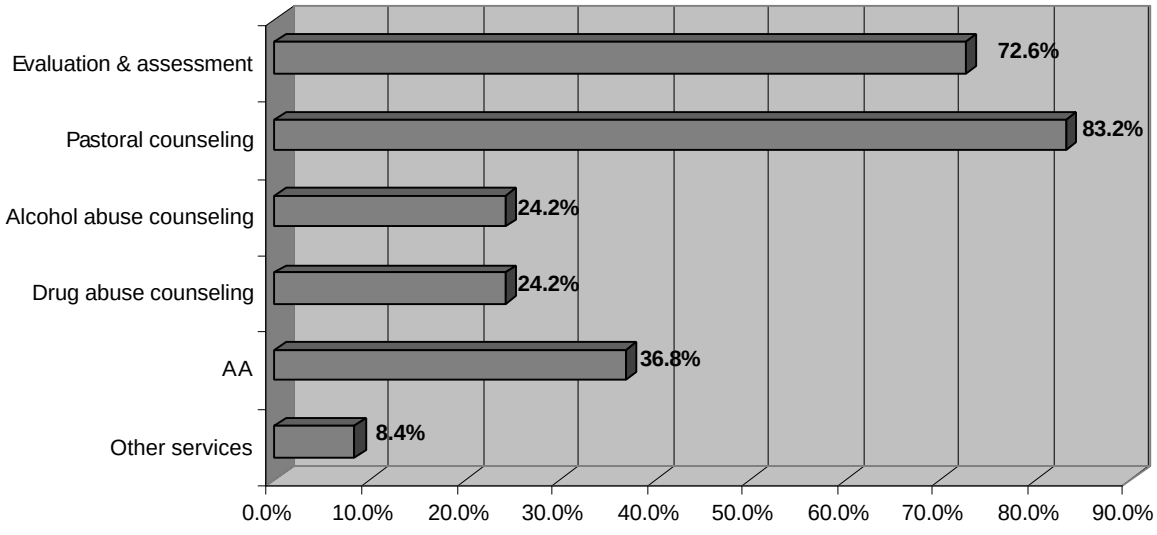
Services Provided in the Jails

Respondents were asked about screening and intake procedures to identify persons with mental illness and services offered within the facility. Almost all jails (96%) asked about medications at intake while 69% asked about mental illness and past use of mental health services and 71% included questions on suicidality. Numbers (and percentages) of jails offering facility-base services were:

- 69 (73%) provided evaluation and assessment, often actually conducted by the mobile crisis team from the local mental health center,
- 79 (83%) provided pastoral counseling, upon request,
- 23 (24%) provided alcohol abuse counseling (24%)
- 23 (24%) provided drug abuse counseling (24%)
- 35 (37%) provided twelve-step groups such as AA or NA.

Other jail-based services included counseling and anger management provided by jail mental health personnel, and medications administered by jail nurse, nurse practitioner or jail physician. Results are illustrated in Table 4. It is interesting to note that while more than half of the total jail population were estimated to have serious substance use problems, alcohol and drug counseling were only provided at 24% of the facilities, and even the low-cost twelve step groups were only offered at 37% of the facilities.

Table 4: Services in the Jails



Jail Diversion Services

Respondents were asked whether an array of jail diversion programs existed in their communities. Specified service types addressed pre-incarceration, incarceration and release phases, building on the concept that effective prevention, treatment provision, planning and service linkage would reduce recidivism.

Law Enforcement:

- 12 (13%) reported having **Specially Trained Police** (e.g. Crisis Intervention Team in Memphis). Those communities that did have this service tended to find it very effective. (See Tables 5 & 7).
- 33 (35%) reported offering **Pre-Booking Jail Diversion** where law enforcement transports offenders to emergency rooms or mental health facilities rather than jail, although many were dissatisfied because of the time officers spent waiting for offenders only to be told that those individuals did not qualify for commitment. (See Tables 5 & 7).
- 14 (15%) reported arrangements for a **24-hour Crisis Triage Center** where law enforcement could drop off offenders at a secure center for mental health assessment. This service was thought to be a critical step in jail diversion in most of the communities where it existed and highly desired by communities where it did not exist. Most other medical and psychiatric facilities required officers to wait until assessments were completed, as long as eight hours, leaving the community under-protected. (See Table 5)
- 40 (42%) reported offering **Post-Booking Jail Diversion** where law enforcement transported offenders to a mental health facility after arrest. Many reported dissatisfaction similar to pre-booking diversion procedures. (See Tables 5 & 7).

Mental Health:

- 81 (85%) had access to **Mobile Crisis Intervention** through the local mental health center. Crisis teams were called to the jail to assess inmates thought to have mental illness. Many respondents expressed frustration that it took so long for the crisis team to arrive. (See Tables 5 & 7).
- 73 (77%) reported access to **Evaluation Specialists,** usually the crisis teams or the criminal justice/mental health liaisons. Jails in urban communities had mental health personnel on staff. (See Table 5).
- 39 (41%) reported some contact with **Mental Health Case Managers** whose clients were incarcerated at the facility. Most reported that contact from case managers was rare either during incarceration or as release approached. Respondents reported that correctional staff notified released inmates of upcoming mental health center appointments, but that there was little monitoring of those referrals either by the jail or the mental health center. (See Table 5 & 7)
- 83 (87%) of respondents reported access to **Medication Evaluation**, either through the mental health center psychiatrist or nurse practitioner, or through medical staff employed by the jail. While medication evaluation was generally seen as effective, dissatisfaction was expressed regarding the cost of newer psychiatric medications and perceived over-prescription to inmates who were

thought to be malingering drug seekers. (See Tables 5 & 7. See Discussion section for more in-depth information on medication costs.)

- 20 (21%) of the jails had access to **Criminal Justice/ Mental Health Liaisons**. As recommended by the Criminal Justice/ Mental Health Task Force of 2000, these boundary spanner personnel worked specifically with individuals with serious mental illness involved in the criminal justice system. Most respondents whose facilities had access to liaisons felt they were effective in preventing recidivism through pre-trial treatment planning, case management during incarceration and service linkage upon release. (See Tables 6 & 7)

Courts:

- 2 (2%) jail systems reported having access to a **Mental Health Court**, a general sessions court with an ameliorative focus similar to drug court. The Davidson County mental health court is currently the only one in Tennessee, and was founded based on Criminal Justice/ Mental Health Task Force recommendations. Respondents stated that the Mental Health Court was effective in diverting persons with serious mental illness from inappropriate incarceration and monitoring community treatment after trial. (See Tables 5 & 7)
- 22 (23%) of the respondents reported having access to a **Drug Court**. Because several drug courts had just started during the period of the survey those respondents were not able to give an opinion on effectiveness. Others reported that the drug courts were generally effective in reducing recidivism, although there was a perception that a large portion of the inmate population was abusing substances. (See Tables 5 & 7)
- 4 (4%) jail systems reported having access to **Probation/Parole** officers with mental health training. Most respondents did not know what sort of training was given to probation or parole units in their community. (See Tables 6 & 7)
- 50 (53%) jail systems reported that the courts in their district used **Conditional Release** to secure residential treatment, more often for substance use than psychiatric treatment. There was ambivalence about the effectiveness of conditional release in reducing recidivism among substance abusing offenders. (See Tables 6 & 7).
- 2 (2%) urban jail systems reported having **Pre-Trial Diversion** services which they felt were very effective in diverting mentally ill offenders from inappropriate incarceration. (See Table 7, “Other”).

County Jails:

- 19 (20%) of the facilities had **Correctional staff** whose duties included **Release Planning** for inmates with mental illness. (See Tables 6 & 7).
- Respondents from 20 (21%) jail systems were able to give exact monthly **psychiatric medication costs**. Of those jail systems costs for psychiatric medication per inmate per month ranged from $23.10 - $1006.50 with an average per inmate per month of $200.35. There did not seem to be a correlation between the size of the jail and psychiatric medication costs. The jail with the highest cost per inmate per month had 120 inmates while the jail with the lowest costs had 51 inmates. The jail with the greatest number of inmates (1800)

spent $125.10 per inmate per month while the jail with the lowest number of inmates that still paid for psychiatric medications spent $23.10 per inmate per month. (See Discussion section for further information.)

Table 5: Jail Diversion Programs

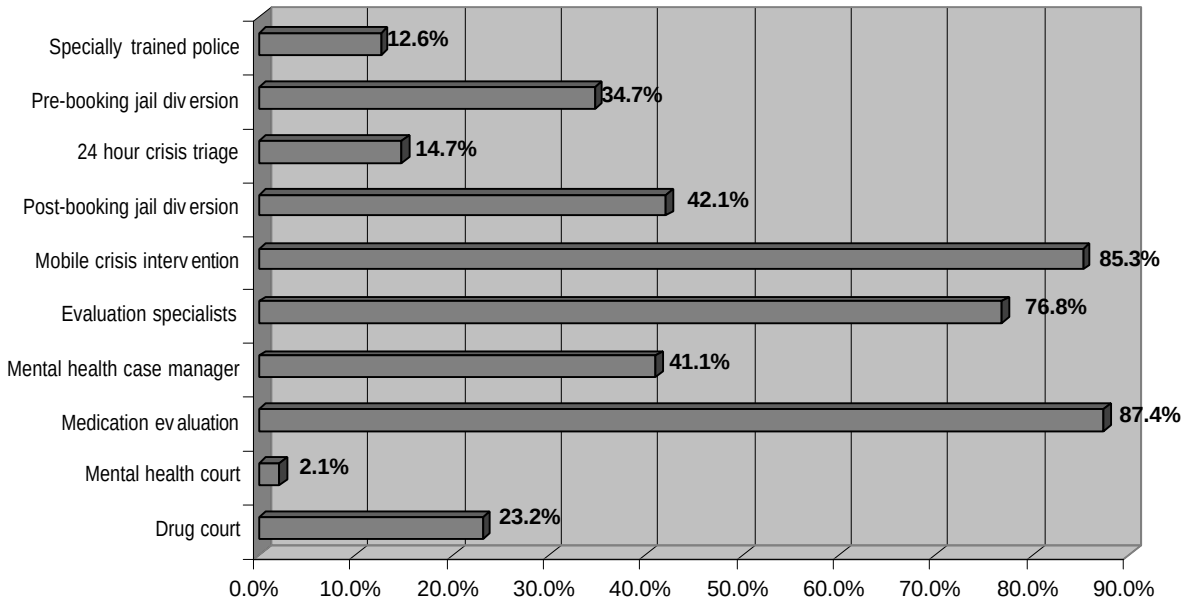


Table 6: Release Procedures

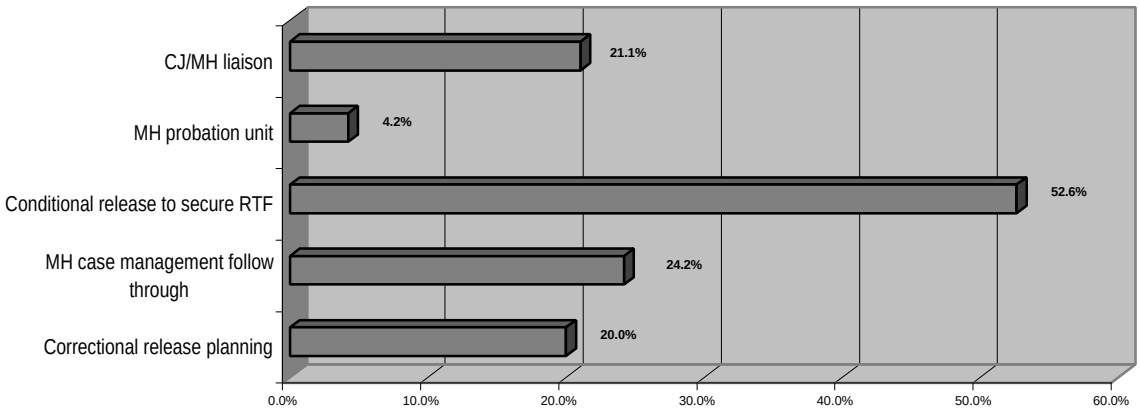
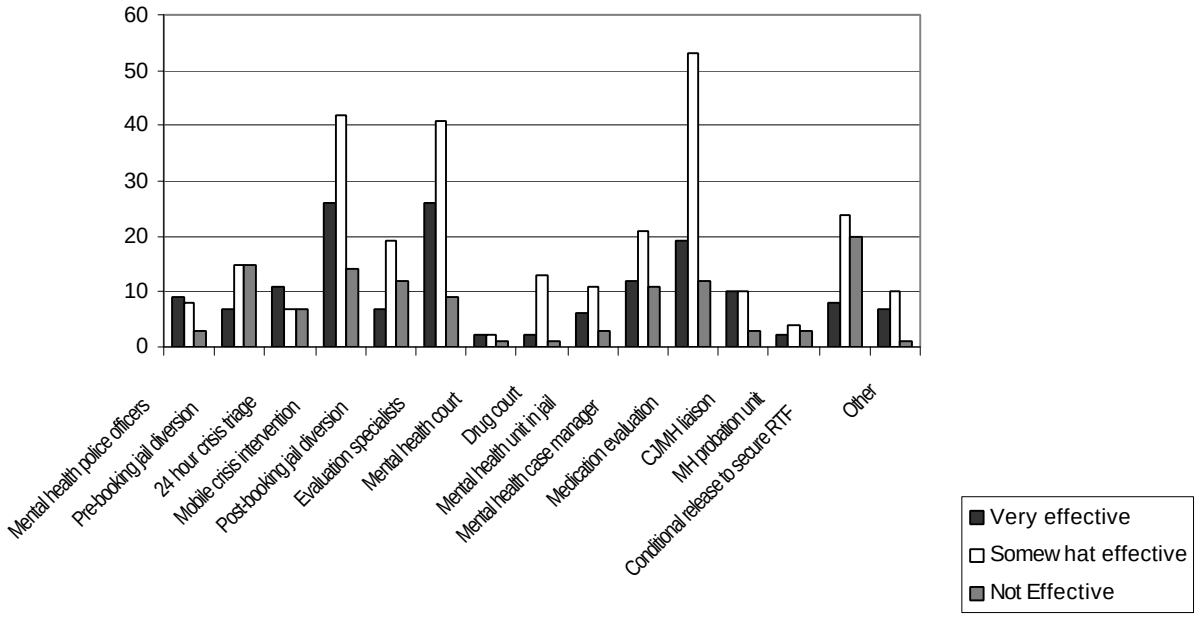


Table 7: Service Effectiveness



Psychiatric Medications

Jails are not established to provide treatment and often do not have the resources to provide access to psychiatric treatment and appropriate medications for inmates with mental illness. Recently developed medications for psychiatric conditions are much more effective than older medications, but are prohibitively expensive. These factors contribute to rising costs of psychiatric medications for county jail inmates, a major concern of the Tennessee sheriffs and county executives.

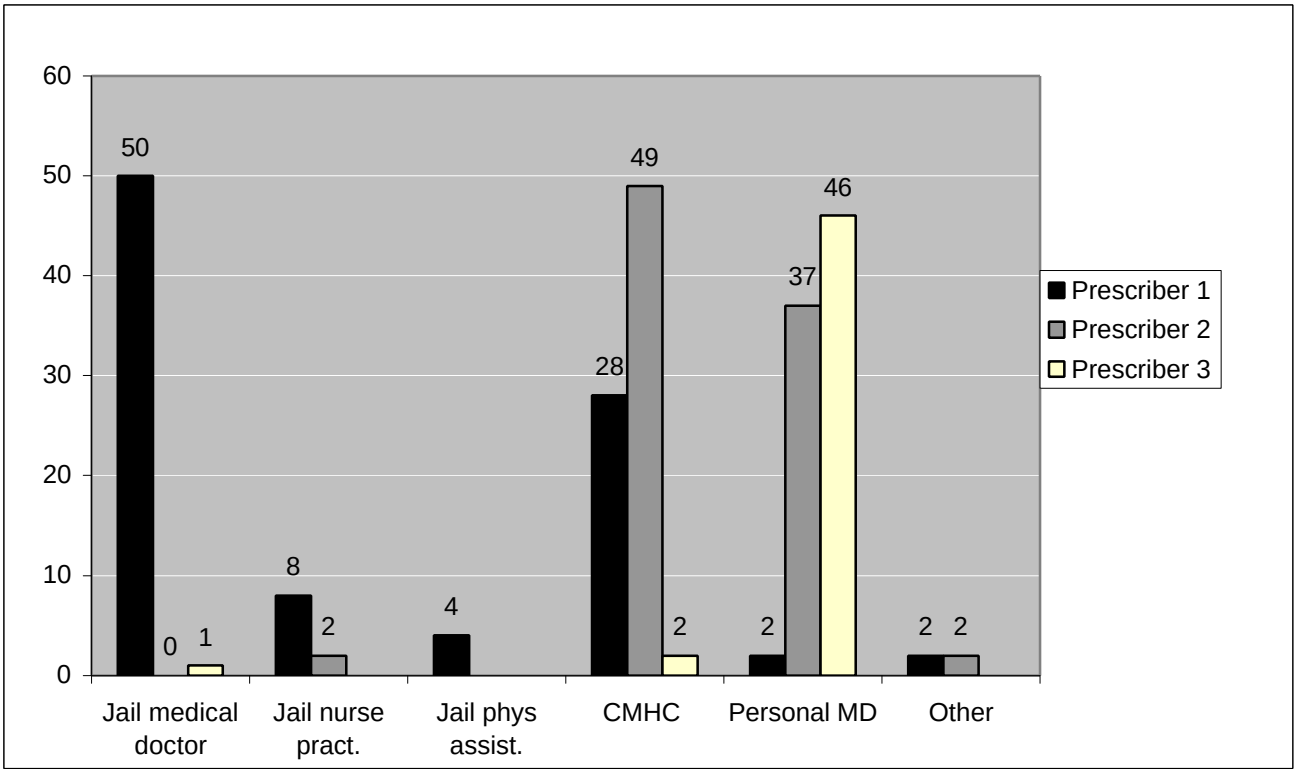
This section examines the types of medical professionals that prescribe psychiatric medications, who purchases medications, types of pharmaceutical suppliers for Tennessee county jails, and costs of psychiatric medications. In a report on prescription drug costs across the state, the Tennessee Comptroller stated, “Many jails do not purchase prescription drugs in a cost-effective manner,” (Morgan, 11/2002, p.ii), and that some jails are not able to provide the most effective treatment for inmates with mental illness due to the cost of psychiatric medications (p.36).

Prescribing Professionals

Psychiatric medications were prescribed by medical staff of the jail, by community mental health center personnel and by the inmates’ personal physicians. Many jail systems reported using more than one type of prescriber. Correctional medical staff included doctors, nurse practitioners and physician’s assistants. Fifty-eight jail systems reported using contract medical personnel and five reported having medical personnel on staff. Community mental health center personnel included

psychiatrists, nurse practitioners and others. Many jails had medical personnel on staff or contract, but still transported non-emergent inmates to the community mental health center for medication evaluation. Transportation and staff time costs contribute to fiscal inefficiency and treatment lag time for inmates. Correctional staff occasionally stated that inmates voiced suicidal ideation in order to be transported to the community mental health center or psychiatric hospital. Inmates who became psychotic or depressed, but were not of danger to self or others often did not see a doctor during brief incarcerations. All but one jail reported having some provision for prescribing psychiatric medications. Table 8 illustrates types of prescribing professionals with as many as three prescribers per jail.

Table 8: Prescribing Professionals



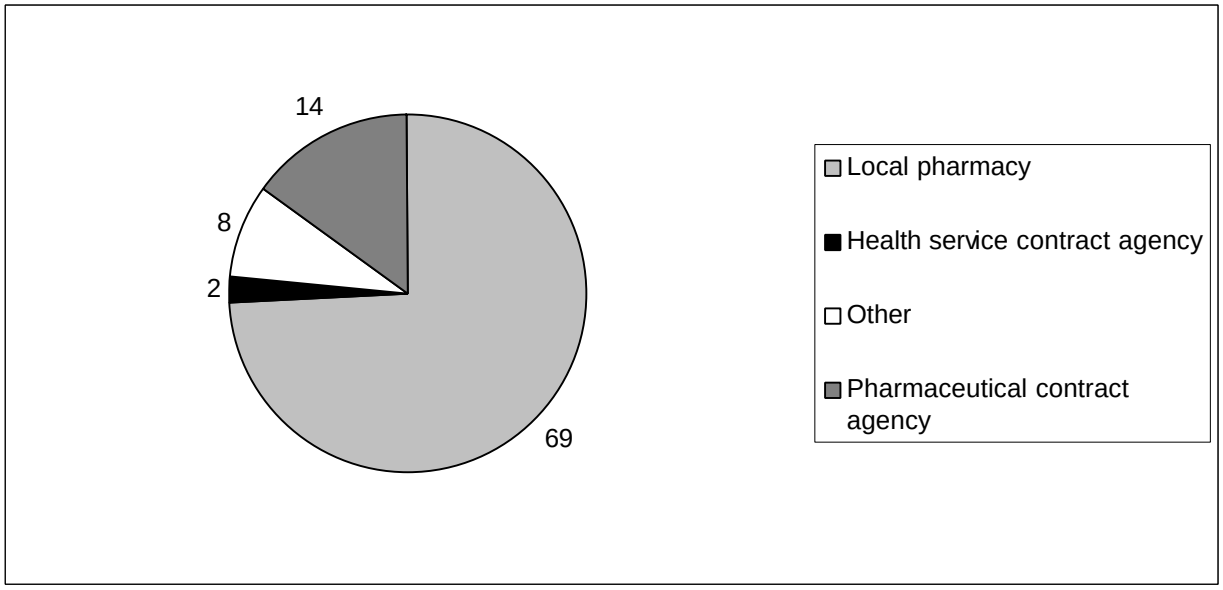
Purchasers

Arrangements to purchase medications were primarily made by the jails or by inmates' family members. Inmates sometimes arrived at the jail with a supply of medications from their personal physician or the community mental health agency. In some jurisdictions medications were checked by nurses or guards and were verified with the local pharmacy or prescribing physician. Some jails required a co-pay of $5.00 per prescription. Others required the inmates on work release to pay the entire cost. Many jails had a procedure whereby the family or inmate's insurance was the first payer, with the jail as a second resort.

Pharmaceutical Suppliers

County jails purchased medications through a variety of suppliers. Most jails purchased medications through local pharmacies. Some split purchasing between two or more local pharmacies in an effort to support local businesses. Some jails contracted with a private firm to provide all healthcare including pharmaceuticals, others contracted with private firms to provide only prescription medications. Figures regarding pharmaceutical suppliers are illustrated in Table 9.

Table 9: Pharmaceutical Suppliers



Costs

Twenty jails (21%) were able to give exact monthly psychiatric medication costs. Of those jail systems, psychiatric medication costs per inmate per month ranged from $23.10 to $1006.50 with and average of $200.35. Seven jails did not pay for medications, but relied on family members to purchase medications and the inmates' insurance or other income to pay for them. The inmate population in those jails ranged from 13 to 115.

Those jails that did purchase medications did not demonstrate a strong correlation between the size of the jail and expenditures for psychiatric medications.

- The jail with highest psychiatric medication cost/inmate/month had 120 inmates,
- The jail with the lowest psychiatric medication cost/inmate/month had 51 inmates,

- The jail with highest inmate population (1800) spent $125.10/inmate/month while the jail with lowest inmate population (51) that had psychiatric medication costs spent $23.10/inmate/month,
- Monthly psychiatric medication costs per jail ranged from $206.90 to $39,963.00 with an average monthly per jail cost of $6,555.13.

Tennessee county jails reported a number of strategies for controlling psychiatric medication costs only some of which provided treatment continuity for inmates with serious mental illness. Larger jail systems established health care contracts, some for all treatment including pharmaceuticals, and some for pharmaceuticals only. Those contracts included reduced rates for medications based on volume of sales. When an expensive medication was prescribed by a physician in the community, jail medical staff at some facilities re-prescribed the lowest cost medication in a class of drugs, for example, a typical vs. atypical anti-psychotic drug. Decisions regarding which medications would or would not be purchased by the jail often rested with the administration rather than the medical staff. Some jails did purchase medications for serious general medical conditions such as diabetes or other life-threatening conditions but did not purchase psychiatric medications. A number of jails did not purchase medications for inmates, but relied on family members to obtain necessary medications for inmates and the inmates' personal insurance or other personal funds to pay for them. The smallest jails transferred inmates needing medications to larger jails. Most jails obtained samples from prescribing physicians whenever possible.

Medication Summary

Various types of medical personnel were responsible for psychiatric prescriptions, only some of whom had specialized psychiatric training. Inefficiencies resulted from having to transport inmates to community mental health agencies for medication evaluation and treatment. Prescribers were often limited to a formulary that only included older, less expensive and less effective medications. Some agencies provided samples to inmates until they had been incarcerated over three months.

Most jails purchased medications through local pharmacies. The larger jails established contracts for purchasing pharmaceuticals, either through a comprehensive medical provider or a pharmaceutical supplier. Some jails did not pay for psychiatric medications, but relied on family members, the inmates' private insurance or other personal funds. Most jails paid for medications out of the county budget.

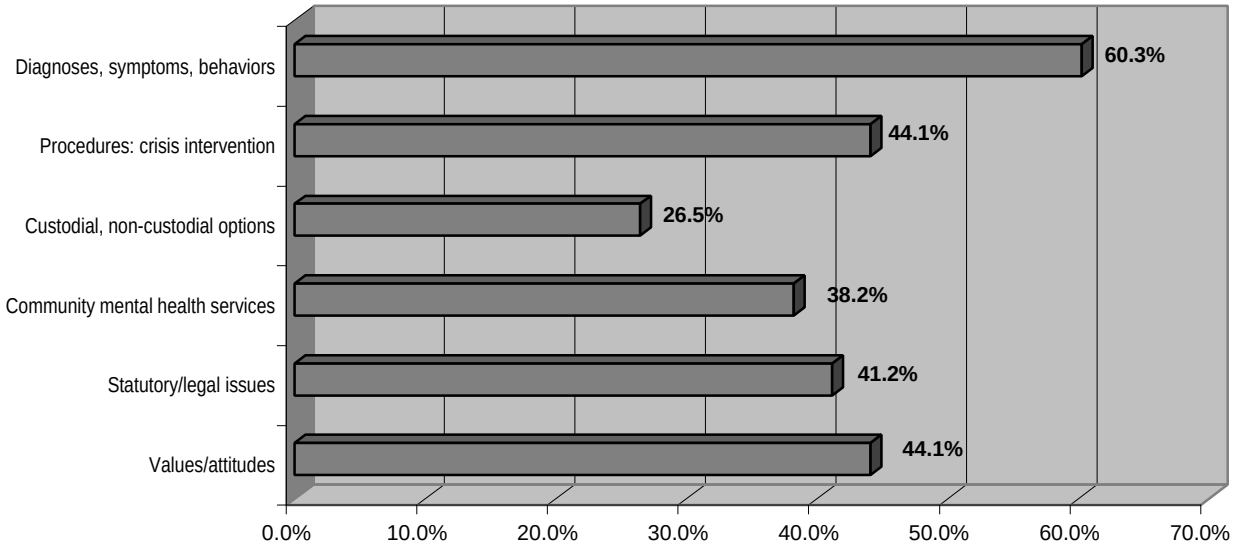
Monthly psychiatric medication costs among county jails in Tennessee, ranged from $206.00 - $39, 963.00 per county jail system. The size of the jail was not a major factor in cost per inmate per month; some of the smaller jails established agreements to purchase pharmaceuticals in a cost-effective manner. Jails used a variety of strategies to control psychiatric medication costs including purchasing agreements with general medical or pharmaceutical contract, obtaining samples from prescribing physicians or relying on inmates and families to pay for some or all pharmaceuticals. Inmates who did not have natural supports in the community and could not afford to pay sometimes

went without needed medication. This contributed to decompensation, reduced quality of life and recidivism.

Training of Correctional Personnel

Respondents were asked about training programs to help correctional staff work with mentally ill inmates. Sixty-eight (72%) of the jail systems reported having mental health training for correctional staff. For 23 jail systems the training reportedly consisted of approximately one hour annually conducted by the Tennessee Corrections Institute (TCI). Eight jail systems supplemented the TCI training with in-service sessions conducted by a variety of instructors including correctional medical staff and mental health center professionals. Twenty-three (35.4%) jail systems indicated that they supplemented TCI training with attendance at quarterly mental health crisis management training conducted by the criminal justice/ mental health liaisons. Eight (12.3%) jail systems indicated that their staff participated in more than 10 hours of training per year, one jail indicating a monthly training session. In addition to the instructors mentioned above, training was provided by Tennessee Protection and Advocacy and NAMI Tennessee. When asked whether they would like more training, 55 (88.7%) of the jail systems responded positively. Topics covered in training are illustrated in Table 10.

Table 10: Training Topics



Discussion

Eighteen percent of the Tennessee jail inmate population was diagnosed with serious mental illness, based on a point in time survey. That rate is still slightly higher than the national average of 16% (Ditton, 1999). However, the number of inmates with serious mental illness incarcerated in county jails appears to have decreased somewhat since 1998.

Jail diversion services such as specialized police units, 24-hour crisis triage centers, mental health courts, criminal justice/mental health liaison personnel and pre-trial diversion services received the highest effectiveness rating from correctional system respondents. Unfortunately these services were only available to a small number of Tennessee communities.

These same respondents perceived the following services to be somewhat effective: post-booking jail diversion, mobile crisis response teams, mental health case managers, drug courts and specialized correctional units for housing mentally ill inmates. Concern was expressed about safety issues and wasted resources related to escorting mentally ill inmates from the jails to evaluation and treatment. Crisis services were perceived as understaffed with lengthy wait times and restrictive eligibility criteria.

Continuum of care between community mental health services and the jails was a concern. It was reported that mental health case managers seldom visited or contacted inmates who were on their caseload. This is largely due to federal Medicaid regulations that prohibit expenditure of Medicaid dollars for services to incarcerated enrollees. With caseloads already high, incarcerated individuals were low on the priority list for case managers. There was concern about treatment planning and service linkage as inmates were prepared for release.

Despite estimates that more than half of the inmate population had serious substance abuse problems, only 24% of the jail systems offered alcohol or drug abuse counseling to inmates and only 37% offered twelve-step groups. National studies estimate that over 75% of the jail population with mental illness have co-occurring substance use disorders (Teplin & Abrams, 1991).

Medication evaluation was thought by respondents to be somewhat effective. Concerns included wait time to get an appointment for medication evaluation, inflexibility of mental health centers if correctional personnel were not able to transport inmates to arrive promptly for appointments, cost of medications, and over-prescription of medications to inmates perceived to be malingering.

Cost of psychiatric medications for inmates was a major concern expressed by the Tennessee Sheriffs Association. Some jail systems have been successful in controlling costs while providing effective medications to inmates. There is a wide range in psychiatric monthly medication costs among county jails in Tennessee, from $206.00 to $39,963.00. However, size of the jail does not seem to be a factor in costs

per inmate per month. While some jails are controlling costs through practices that are not beneficial to the mental health of inmates, others have negotiated workable solutions.

Best Practices

The national Criminal Justice/ Mental Health Consensus Project recommended best practices for dealing with offenders who have serious mental illness throughout the criminal justice and mental health treatment process. Many of these recommendations do not require increased expenditures, and some could be expected to reduce overall costs of dealing with this population. The Consensus Project established an assessment and planning process with national criminal justice and mental health experts. The report (Consensus Project, 2002) contained 46 policy statements about best mental health and criminal justice practices concerning persons with serious mental illness who are involved in the criminal justice system.

Criminal Justice Approaches

Recommended law enforcement practices include dispatch and on-scene assessment, on-scene response protocols, documentation procedures and post-incident collaboration with mental health partners to reduce the need for contact between the police and persons with serious mental illness who commit minor offenses. Tennessee also has the nationally recognized Crisis Intervention Team (CIT) (Dupont, 2001) in Memphis, intensively trained police officers that respond to cases where mental illness is a factor. CIT officers have an agreement with a local hospital allowing them to drop off an offender with serious mental illness at a 24-hour crisis triage center.

Judicial best practices include informing defense counsel of the defendant's mental health condition, treatment resources, and pertinent case law; educating victims about mental illness, use of pretrial diversion, judicial use of dispositional alternatives and sentencing options, and modifying conditions of probation or supervised release. Mental health courts show promise as a forum in which to embody these principles (Goldkamp & Irons-Guynn, 2000).

Correctional best practices involve improved and consistent screening/intake procedures that assess for mental illness and substance abuse, collaboration with mental health personnel to develop treatment and transition plans that follow the inmate after release, use of clinical expertise to make release decisions, monitoring compliance with conditions of release and rapid response to violations. It is essential to ensure that people with mental illness who are no longer under criminal justice supervision maintain contact with mental health services and receive supports as long as necessary.

Best Practices in Mental Health Treatment

A group of "evidence based practices" for mental health treatment and rehabilitation have been developed and evaluated under a variety of conditions across the nation. Experts feel that broad implementation of these practices would result in numerous benefits, including involvement of fewer persons with serious mental illness in the criminal justice system.

Newer medications much more effectively relieve symptoms of mental illness and have far fewer side effects. Because of this, mental health consumers are more likely to follow treatment regimens. However, the newer medications are extremely expensive. Jails, using resources from county budgets, are not able to support consistent administration of these medications. Inmates with older medications may experience more side effects and less treatment benefit while incarcerated, and are much less likely to continue taking the medication upon release.

While public systems have failed those few individuals with serious mental illness who are repeatedly arrested for minor crimes, confining those individuals to long-term institutional care would be neither humane nor cost-effective. Instead, intensive community services should be provided to this population. Assertive community treatment involves a mobile, multi-disciplinary team that is available 24 hours per day. The team includes a psychiatrist, nurse, and case managers with low caseloads who can attend to intensive needs of persons with serious mental illness who are unstable. Twenty-five years of research have demonstrated the effectiveness of this approach with hard-to-treat individuals. Research on people who are hospitalized following a violent incident indicates that the most critical time to intensively monitor these individuals upon discharge is the first 10 weeks, but a slightly less intensive monitoring for at least a year is recommended (Monahan et al, 2001).

Supported employment is a rehabilitative approach that assists people with serious mental illness to obtain employment in the competitive market. Pre-employment assessment, skill training and development, and peer social support help the individual transition into part-time or full-time employment with assistance from a job coach. This method has an excellent track record of assisting people with serious mental illness to obtain and maintain employment.

In family psychoeducation, clinicians educate consumers and their families to understand mental illness, mental health treatment and coping skills. This could be a critical practice for persons with mental illness who are involved in the criminal justice system. Research indicates that most of the targets of violent acts by persons with serious mental illness are domestic partners or other family members, and most violent acts occur in the person's place of residence (Estroff, et al, 1998, Monahan et al, 2001). Families who are educated and prepared may be able to stop incidents before they escalate to the point where law enforcement must be involved.

Experts estimate that 75% of the inmates with serious mental illness have co-occurring substance use disorders (Teplin & Abram, 1991). Integrated treatment for

dual disorders is a best practice method that addresses both types of problems at once, creating better outcomes on both fronts (Drake et al, 2001). Integrated treatment should be provided in the jails and could be included as a condition of probation when available.

Supported housing is necessary for the most disabled persons with serious mental illness. Supported housing programs provide housing and on-site support to maintain treatment regimens, manage finances, do domestic tasks and integrate socially with one's neighbors. Federal guidelines currently limit assistance to individuals with criminal records. Policy barriers must be addressed in order to facilitate housing access for this population (Culhane et al, 2001).

Recommendations

The following recommendations are based on findings from this study and information from the wider criminal justice and mental health literature. Some of the recommendations were made previously by the Criminal Justice/ Mental Health Task Force, but have not yet been fully implemented.

Start upstream. Improve preventive pre-arrest and jail diversion procedures.

- Establish family education to assist at-risk families with crisis de-escalation.
- Establish law enforcement and correctional protocols for standardized dispatch and on-scene and pre-booking mental health assessment where mental illness may be a factor.
- Improve pre-booking jail diversion service agreements between the criminal justice and mental health system.
- Improve documentation procedures and post-incident collaboration between criminal justice and mental health personnel.

Go with what works. Replicate effective services in more Tennessee communities.

Jail diversion services such as specialized police units, 24-hour crisis triage centers, mental health courts and criminal justice/mental health liaison personnel received high ratings from respondents. Services could be established on a regional basis in less populated areas of the state.

Bring public mental health services to where the consumers are, in the jails.

Assessment, case management and medication evaluation/monitoring are regular, ongoing needs in the jails. Establish regular visits in the jail setting by assessment clinicians, nurse practitioners, and case managers. Utilizing jail personnel to escort consumers to mental health services increases the stigma factor and the potential for safety concerns. Telemedical assessment could be an option for small rural jails.

Stop the revolving door. Provide intensive, assertive community treatment to those few individuals with mental illness who frequently cycle through the criminal justice system.

An assertive, multi-disciplinary, system-spanning approach is needed to assist these individuals to establish stable, productive roles in the community and to safeguard their families and communities. Services should be prepared to serve individuals with co-occuring disorders including mental illness, substance abuse, developmental disability and/or physical disability. A jurisdiction-based regional approach could be taken in less populated areas of the state.

Maintain continuity of care by promoting case management activity to continue during incarceration.

Case managers could play a vital role in assuring that jail personnel and the courts have the information needed to assure provision of mental health treatment for consumers during incarceration. Case management services can also assist with release planning to assure a smooth transition back into the community and linkage to mental health services. Case managers should be required to visit incarcerated consumers face to face in jail to suspend service during incarceration and should be informed of impending release in order to reconnect the consumer with community services and supports. A 90 day notice should be given to case managers of prisoners due for release from state prisons to develop transition services and supports immediately upon release. Mechanisms must be developed to reimburse provider agencies for these services.

Bring substance abuse assessment, treatment and self-help groups to more jails.

Over half of the inmates in Tennessee county jails have serious substance abuse issues. Providing treatment while incarcerated may intervene at a critical time in the individual's addiction process. Conditional release to community treatment would reinforce gains made while incarcerated. Participation in self-help groups while incarcerated with referrals to community-based groups upon release would assist the recovery process.

Develop strength in numbers: use collective bargaining to provide effective medication and control costs.

Information about psychiatric medication costs to county jails in Tennessee suggests that a collective effort at purchasing medications and controlling costs would be beneficial and cost effective. County jails could work through the Tennessee Sheriffs Association with assistance from the Tennessee Department of Mental Health and Developmental Disabilities, Department of Corrections, the TennCare Bureau and the Comptroller to develop arrangements to provide effective medications at an affordable cost.

Pull together. Gaps must be closed between public mental health, substance abuse and criminal justice policies. Sufficient resources must be allocated to implement policy changes successfully.

Continue to work toward implementing the Mental Health and Criminal Justice Task Force recommendations of 2000:

- **Establish and monitor standards of care for incarcerated persons with mental illness.** Develop legislation to give the appropriate agency authority to develop and enforce standards of care for incarcerated persons with mental illness and those with co-occurring substance use disorders. Tennessee Corrections Institute, Division of Mental Health Services and Department of Corrections should collaborate to develop and monitor standards for release planning to ensure continuity of care;

- Allocate resources to **provide mental health and substance abuse treatment in the jails**, blending funding streams where necessary to establish a seamless system of care;

- **Do not disenroll TennCare recipients with serious mental illness who enter the criminal justice system.** Suspend TennCare benefits, then reinstate upon release for those persons serving less than one year;

- **Develop an expedited TennCare application process** for eligible persons with mental illness who are incarcerated to ensure quick access to benefits upon release; and

- **Amend Title 33 to allow alternative transportation of non-violent persons** for commitment evaluation by agents other than sheriffs departments. This could include responsible others if deemed safe.

The Tennessee Department of Mental Health and Developmental Disabilities is currently working on the following education and training recommendations with funding from an Edward R. Byrne grant to establish the Tennessee Mental Health and Criminal Justice Training Program. The following recommendations fall under the purview of the project:

- **Educate the workforce. Train mental health personnel regarding issues and best practices for incarcerated individuals with mental illness.** Establish continuing education credits for training wherever appropriate. Possible topics include:
  - Assessment for mental illness, co-occurring substance abuse, suicidality and malingering in the criminal justice population;
  - Effective prescribing practices;
  - Service linkage issues;
  - Release planning: housing, health coverage and resource considerations;
  - Statutory/ regulatory requirements for service provision (Title 33, TennCare, Medicaid, etc.); and

- Educate **crisis responders regarding conditions in the criminal justice system** to encourage provision of the same level of service to persons involved with criminal justice issues as with other persons experiencing mental health crises in the community.

- **Train criminal justice personnel regarding issues and best practices for offenders and inmates with mental illness**.

  - **Continue and refine current Tennessee Corrections Institute and law enforcement** training regarding:
    - Signs and symptoms of mental illness, substance abuse, suicidality;
    - Crisis intervention procedures;
    - Assessment and intake procedures;
    - Jail diversion and release procedures;
    - Community mental health service access procedures; and
    - Statutory requirements.

  - **Develop training for judicial personnel**. Establish continuing education credits for training wherever appropriate. Topics include:
    - Mental illness: what it is, what it isn't, what to do;
    - Defense counsel alternatives for obtaining psychiatric evaluation & treatment resources;
    - Judicial use of dispositional alternatives and sentencing options; and
    - Judicial alternatives for modifying conditions of probation or supervised release.

Appendix A

Synopsis: Criminal Justice Task Force Recommendations, FY 2000

Mental Health Recommendations: *

- The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) should develop pilot projects that can be replicated statewide, such as *single port of entry*, *boundary spanners*, pre and post-trial case management services, and *mental health courts*.
- Crisis response services should develop a policy requiring crisis responders to provide the same level of service to persons involved with law enforcement and corrections personnel as with other persons experiencing mental health crises.
- *TDMHDD should work toward increasing appropriate housing options for persons with mental illness who have been involved in the criminal justice system*.

Criminal Justice Recommendations: *

- Pass legislation to give the appropriate agency authority to develop and enforce standards of care for incarcerated persons with mental illness and those with co-occurring substance use disorders.
- Tennessee Corrections Institute, Division of Mental Health Services and Department of Corrections should develop and monitor standards for release planning to ensure continuity of care.
- Community correctional facilities should use a standardized mental health assessment and screening tool.

Training Recommendations: *

- *Criminal justice personnel and mental health personnel should receive specialized, multidisciplinary training at core training courses and follow-up in-service sessions*
- *Provide resources to deliver training through the Tennessee Peace Officer Standards and Training (POST) and the Tennessee Corrections Institute (TCI).*
- Community mental health agencies should identify personnel who can receive specialize training on the criminal justice system.

System Recommendations: *

- TennCare should identify, not disenroll recipients with serious mental illness who enter the criminal justice system. Benefits should be suspended then reinstated upon release.
- Bureau of TennCare should develop an expedited application process for eligible persons with mental illness who are incarcerated to ensure quick access to benefits upon release.
- Implement Title 33
    - Philosophy promoting community-based services and accountability to the public,
    - 24 – 72 hour observation service for individuals with mental illness who are experiencing severe impairment
    - Transportation to involuntary hospitalization by alternative transporting agents, other than sheriffs departments.
- *Carry on the work of the Task Force through a Criminal Justice Advisory Committee of the Tennessee Mental Health Planning and Policy Council.*

**Italicized recommendations have been implemented.*

Appendix B

Tennessee Survey of County Jails

Criminal Justice/Mental Health Advisory Committee

Introduction:

The purpose of this survey is to gather information about services for people with mental illness who are arrested on criminal charges. Please think about services provided at your facility and complete this survey to the best of your ability. Your answers will help improve mental health and criminal justice services for persons with mental illness in Tennessee.

1. Does your facility have a screening form that asks questions regarding:

Mental illness?	? Yes	? No	? Don't know
Suicide?	? Yes	? No	? Don't know
Medications?	? Yes	? No	? Don't know

2. Which of the following services does your facility offer to inmates with mental illness?

Evaluation and assessment	? Yes	? No	? Don't know
Pastoral counseling	? Yes	? No	? Don't know
Alcohol abuse counseling	? Yes	? No	? Don't know
Drug abuse counseling	? Yes	? No	? Don't know
Alcoholics Anonymous	? Yes	? No	? Don't know
Other services (specify: _____ _____)	? Yes	? No	? Don't know

2a. What was the total expenditure last month on psychiatric medications for inmates at your facility?
[see list of medications on page 6]

$_____.___

3. Does your facility provide special mental health housing for mentally ill inmates?
[If no, skip to question 4.]

? Yes	? No	? Don't know

3a. If yes, what is the capacity of this housing? #_____ beds | ? Don't know

4. Does your community have a program to divert mentally ill offenders to treatment as rather than incarceration when appropriate? *[If no, skip to question 5.]*
[Question 4a provides examples of mental health jail diversion programs.]

? Yes	? No	? Don't know

4a. If yes, which of the following jail diversion programs operate in your community?

Specially trained police officers attend to cases where mental illness is a factor.	? Yes	? No	? Don't know
Pre-booking jail diversion: police officers escort offender to mental health agency rather than arrest.	? Yes	? No	? Don't know
24-hour crisis triage center: police officers deliver mentally ill offenders to secure center in medical or mental health facility rather than jail or emergency room.	? Yes	? No	? Don't know
Crisis intervention: mobile crisis intervention teams from mental health agency attend to cases with, or instead of, police officers.	? Yes	? No	? Don't know
Post-booking jail diversion: after arrest police officers escort offender to mental health service instead of jail.	? Yes	? No	? Don't know
Screening/evaluation specialists: emergency clinicians evaluate offenders suspected of having mental illness or substance abuse issues. Can be clinicians from a mental health agency who work on a rotating basis.	? Yes	? No	? Don't know
Mental health court: mentally ill offender is brought before special court. Court strives for least restrictive, most appropriate disposition for defendants. Court monitors delivery of services.	? Yes	? No	? Don't know
Drug court: similar to mental health court for defendants with substance abuse issues.	? Yes	? No	? Don't know
Special mental health unit in jail: offenders who have mental illness are housed apart from regular jail population. Emphasizes treatment/ rehabilitation rather than punishment.	? Yes	? No	? Don't know
Mental health case management: personnel from mental health agencies visit offenders with mental illness during incarceration. Treatment plan carries forward upon release.	? Yes	? No	? Don't know
Medication evaluation of mentally ill inmates by a psychiatrist or nurse practitioner during incarceration. Treatment plan carries forward upon release.	? Yes	? No	? Don't know
Other (specify: _____ _____)	? Yes	? No	? Don't know

5. Does your facility have a procedure to link the mentally ill offenders to local mental health services after release from jail? *[If no, skip to question 6.]*

? Yes	? No	? Don't know

5a. If yes, what type of procedures do you have?

Jail liaison personnel: refer mentally ill offenders to mental health agency and participate in transitional treatment planning.	? Yes	? No	? Don't know
Referral to special probation/parole unit: specially trained probation/parole officers work with mental health clinician to secure treatment, housing, etc.	? Yes	? No	? Don't know
Conditional release to secure residential treatment: secure facility provides treatment to offenders with mental illness/substance abuse issues.	? Yes	? No	? Don't know
MH Case management: personnel from mental health agency visit mentally ill offenders throughout booking, incarceration and release	? Yes	? No	? Don't know
Correctional case management: personnel of correctional facility who handle routine issues (property, court dates, etc.) Some may focus on offenders with mental illness.	? Yes	? No	? Don't know
Other services (specify: _____ _____)	? Yes	? No	? Don't know

6. Please give us your opinion of how effectively the following services help inmates with mental Illness at your facility.

Service Type	Very effective	Somewhat effective	Not effective	None in this community
Specially trained police officers	1	2	3	8
Pre-booking jail diversion	1	2	3	8
24-hour crisis triage center	1	2	3	8
Crisis intervention	1	2	3	8
Post-booking jail diversion	1	2	3	8
Screening/evaluation specialists	1	2	3	8
Mental health court	1	2	3	8
Drug court	1	2	3	8
Special mental health unit in jail	1	2	3	8
Mental health case managers	1	2	3	8
Medication evaluation	1	2	3	8
Jail liaison personnel	1	2	3	8
Special probation/parole unit	1	2	3	8
Release to secure residential treatment	1	2	3	8
Other: (specify: _____)	1	2	3	8

7. Do you have a training program for jail/correctional officers who deal with mentally ill inmates?
[If no, skip to question 8.]

? Yes	? No	? Don't know

7a. If yes, how many hours of training? #_____ hours | ? Don't know

How often? *[check the most appropriate response.]*

?	Weekly
?	Monthly
?	More than once per year
?	Once per year
?	Less than once per year
?	Don't know

7b. If yes, what are the topics covered in training?

Diagnoses, symptoms, behaviors, etc.	? Yes	? No	? Don't know
Procedures: Crisis intervention (non-forceful take-down, communication, problem-solving, etc)			
Custodial, non-custodial options	? Yes	? No	? Don't know
Community options: mental health services	? Yes	? No	? Don't know
Statutory/ legal issues	? Yes	? No	? Don't know
Values/ attitudes	? Yes	? No	? Don't know
Other (specify: _____)	? Yes	? No	? Don't know

7c. If training is provided, describe the professional background of the instructor(s)?
[Check all that apply.]

TN Corrections Institute	? Yes	? No	? Don't know
Community mental health agency personnel ? Psychiatrist ? Psychologist ? Social Worker ? Other (specify: _____)	? Yes	? No	? Don't know
Private mental health professional ? Psychiatrist ? Psychologist ? Social Worker ? Other (specify: _____)	? Yes	? No	? Don't know
Criminal justice/ mental health liaison personnel	? Yes	? No	? Don't know
Tennessee Protection and Advocacy personnel	? Yes	? No	? Don't know
Other (specify: _____)	? Yes	? No	? Don't know

7d. If additional training were offered, would your facility be interested in participating?

? Yes	? No	? Don't know

8. In your opinion, has the number of inmates with mental illness in your facility increased or decreased in the past 12 months?

? Increased	? Decreased	? Don't know

8a. Thinking of last Sunday morning, provide your best estimate of the total number of adults (age 21 and over) in jail at your facility and the number with mental illness. Please complete the column regarding "inmate population as a whole" even if you do have information to complete the other columns.

	Inmate population as a whole	Pre-adjudication (before trial)	Serving less than a year (after trial)	Serving a year or more after trial)	Don't know
Total number of inmates in jail	_____	_____	_____	_____	?
Number with serious substance abuse problems	_____				?
Number with *diagnosis* of mental illness *	_____				?
Number who exhibit behaviors suggesting mental illness, but not diagnosed	_____				?
Number who have voiced suicidal thoughts or made suicidal gestures.	_____				?
Number receiving psychiatric medications **	_____				?

* Common psychiatric diagnoses include:

depression
bipolar disorder
schizophrenia
other psychotic disorder
posttraumatic stress disorder
dissociative identity disorder
obsessive compulsive disorder

Please do *not* include antisocial personality disorder or borderline personality disorder.

** Some common psychiatric medications include:

Ativan (lorazepam)	Geodon (ziprasidone)	Paxil (paroxetine)	Thorazine (chlorpromazine)
Buspar (buspirone)	Haldol (haloperidal)	Prolixin (fluphenazine)	Tofranil (imipramine)
Celexa (sertraline)	Klonopin (clonazepam)	Prozac (fluoxetine)	Topimax (topiramate)
Clozaril (clozapine)	Lamictal (lamotrigene)	Remeron (mirtazapine)	Valium (diazepam)
Depakote (valproic acid)	Lithobid (lithium)	Risperdal (risperdone)	Welbutrin (buproprion)
Desyrel (trazodone)	Nardil (phenelzine)	Seroquel (quetapine)	Xanax (alprazolam)
Effexor (venlafaxine)	Neurontin (gabapentin)	Serzone (nefazodone)	Zoloft (sertraline)
Elavil (amitriptyline)	Parnate (tranylcypromine)	Tegretol (carbemazepine)	Zyprexa (olanzepine)

Thank you for taking the time to complete this questionnaire.
Results will be published by June 30, 2003.

For a copy of the report contact:
Liz Ledbetter, Criminal Justice Liaison
Tennessee Department of Mental Health and Developmental Disabilities
Cordell Hull Building, 425 5th Avenue North, Third Floor, Nashville, TN 37243

Appendix C

Jail Survey Results

1. Does your facility have a screening form that asks questions regarding:

N = 95	# Yes	% Yes
Mental illness?	66	69%
Suicide?	67	71%
Medications?	91	96%

2. Which of the following services does your facility offer to inmates with mental illness?

N = 95	# Yes	% Yes
Evaluation and assessment	69	73%
Pastoral counseling	79	83%
Alcohol abuse counseling	23	24%
Drug abuse counseling	23	24%
Alcoholics Anonymous	35	37%

Other jail-based services:

- Counseling and anger management provided by jail mental health personnel .
- Medications administered by jail nurse, nurse practitioner, jail physician.

2a. What was the total expenditure last month on psychiatric medications for inmates at your facility?

	Exact N=20	Estimate N=58
Mean	$ 4,319.88	$ 2,886.22
Medium	$ 1,730.56	$ 1,400.00
Minimum other than 0	$ 23.10	$ 0.03
Maximum	$,39,963.00	$ 30,000.00
Su m	$112,316.82	$167,401.00

3. Does your facility provide special mental health housing for mentally ill inmates?

N = 95	# Yes	% Yes
	31	33%

3a. If yes, what is the capacity of this housing?

	N=31
Mean	14
Minimum	0
Maximum	113

4. Does your community have a program to divert mentally ill offenders to treatment as rather than incarceration when appropriate?

N = 95	# Yes	% Yes
	31	33%

4a. If yes, which of the following jail diversion programs operate in your community?

N = 95	# Yes	% Yes
Specially trained police officers attend to cases where mental illness is a factor.	12	13%
Pre-booking jail diversion: police officers escort offender to mental health agency rather than arrest.	33	35%
24-hour crisis triage center: police officers deliver mentally ill offenders to secure center in medical or mental health facility rather than jail or emergency room.	14	15%
Crisis intervention: mobile crisis intervention teams from mental health agency attend to cases with, or instead of, police officers.	81	85%
Post-booking jail diversion: after arrest police officers escort offender to mental health service instead of jail.	40	42%
Screening/evaluation specialists: emergency clinicians evaluate offenders suspected of having mental illness or substance abuse issues. Can be clinicians from a mental health agency who work on a rotating basis.	73	77%
Mental health court: mentally ill offender is brought before special court. Court strives for least restrictive, most appropriate disposition for defendants. Court monitors delivery of services.	2	2%
Drug court: similar to mental health court for defendants with substance abuse issues.	22	23%
Special mental health unit in jail: offenders who have mental illness are housed apart from regular jail population. Emphasizes treatment/ rehabilitation rather than punishment.	20	21%
Mental health case management: personnel from mental health agencies visit offenders with mental illness during incarceration. Treatment plan carries forward upon release.	39	41%
Medication evaluation of mentally ill inmates by a psychiatrist or nurse practitioner during incarceration. Treatment plan carries forward upon release.	83	87%

Other jail diversion services:

- Pretrial jail diversion services reported in 2 urban jails, referral to mental health treatment

5. Does your facility have a procedure to link the mentally ill offenders to local mental health services after release from jail?

N = 95	# Yes	% Yes
	70	74%

5a. If yes, what type of release procedures do you have?

N = 95	# Yes	% Yes
Jail liaison personnel: refer mentally ill offenders to mental health agency and participate in transitional treatment planning.	20	21%
Referral to special probation/parole unit: specially trained probation/parole officers work with mental health clinician to secure treatment, housing, etc.	4	4%
Conditional release to secure residential treatment: secure facility provides treatment to offenders with mental illness/substance abuse issues.	50	53%
MH Case management: personnel from mental health agency visit mentally ill offenders throughout booking, incarceration and release	23	24%
Correctional case management: personnel of correctional facility who handle routine issues (property, court dates, etc.) Some may focus on offenders with mental illness.	19	20%

6. Please give us your opinion of how effectively the following services help inmates with mental Illness at your facility.

Service Type	Very effective	Somewhat effective	Not effective	None in this community
Specially trained police officers	9	8	3	72
Pre-booking jail diversion	7	15	15	56
24-hour crisis triage center	11	7	7	69
Crisis intervention	26	42	14	11
Post-booking jail diversion	7	19	12	53
Screening/evaluation specialists	26	41	9	18
Mental health court	2	2	1	88
Drug court	2	13	1	73
Special mental health unit in jail	6	11	3	73
Mental health case managers	12	21	11	50
Medication evaluation	19	53	12	9
Jail liaison personnel	10	10	3	71
Special probation/parole unit	2	4	3	84
Release to secure residential treatment	8	24	20	41

7. Do you have a training program for jail/correctional officers who deal with mentally ill inmates?

N = 95	# Yes	% Yes
	68	72%

7a. If yes, how many hours of training?

N = 65	#	%
Don't know	3	4.6%
1 hour	23	35.4%
2 – 6 hours	8	12.3%
8 hours	23	35.4%
10+ hours	8	12.3%

How often?

N = 68	#	%
Monthly	1	1.5%
More than once per year	20	29.4%
Once per year	42	61.8%

7b. If yes, what are the topics covered in training? *[indicate all that apply]*

N = 68	#	%
Diagnoses, symptoms, behaviors, etc.	41	60.3%
Procedures: crisis intervention	30	44.1%
Custodial, non-custodial options	18	26.5%
Community options: mental health services	26	38.2%
Statutory/legal issues	28	41.2%
Values/attitudes	30	44.1%

7c. If training is provided, describe the professional background of the instructor(s)?

	#
Tennessee Corrections Institute	51
Mental Health Center Psychiatrist	1
Other Mental Health Center Personnel	10
Criminal Justice/Mental Health Liaison	24
Tennessee Protection and Advocacy	2
Other	7

7d. If additional training were offered, would your facility be interested in participating?

N = 62	# Yes	% Yes
	55	88.7%

8. In your opinion, has the number of inmates with mental illness in your facility increased or decreased in the past 12 months?

N = 95	#	%
Increased	70	73.7%
Stayed the same	9	9.5%
Decreased	7	7.4%
Don't know	9	9.5%

8a. Thinking of last Sunday morning, provide your best estimate of the total number of adults (age 21 and over) in jail at your facility and the number with mental illness. Please complete the column regarding "inmate population as a whole" even if you do have information to complete the other columns.

	Exact #	% of Exact Total	Estimated #	% of Estimated Total	Combined #	Combined %
Total number of inmates in jail N=95	9911	66.2%	4160	27.8%	14971	100%
Number with serious substance abuse problems N=85	798	33.1%	7083	61.5%	7881	52.6%
Number with *diagnosis* of mental illness N=84	588	10.4%	1921	22.7%	2509	16.7%
Number who exhibit behaviors suggesting mental illness, but not diagnosed N=71	365	6.0%	577	15.1%	942	6.3%
Number who have voiced suicidal thoughts or made suicidal gestures. N=91	204	1.9%	111	2.7%	315	2.1%
Number receiving psychiatric medications N=83	1383	15.6%	1748	31.3%	3040	20.3%

8a. Thinking of last Sunday morning, provide your best estimate of the total number of adults (age 21 and over) in jail at your facility who are incarcerated pre-trial, or serving sentences less than one year or one year or more after trial.

N=28	#	%
Pre-adjudication (pre-trial)	1241	43.9%
Serving less than a year after trial	898	31.8%
Serving a year or more after trial	679	24.0%
Inmate population as a whole	2826	100%

References

Council of State Governments (2002) *Criminal Justice/Mental Health Consensus Project,* Lexington, KY, *www.consensusproject.org*.

Culhane, DP; Metraux, S; Hadley, T (2001) "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems," Housing Policy Debate 12.

Ditton, PM (1999) *Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers*. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Drake, RE; Essock, SM; Shaner, A; Carrey, K; Minkoff, K; Kola, L; Lynde, D; Osher, FC; Clark, RE; Rickards (2001) Implementing Dual Diagnosis Services for Clients with Severe Mental Illness. *Psychiatric Services* 52, 469-76.

Dupont, R (1998) *A study of Mental Illness in the Shelby County Jail*, University of Tennessee, Department of Psychiatry, Memphis, TN.

Dupont, R (2001) How the Crisis Intervention Team Model Enhances Policing and Community Mental Health. *Community Mental Health Report*, Nov/Dec.

Estroff, SE; Swanson, JW; Lachicotte, WS; Swartz, M, Bolduc, M (1998) Risk Reconsidered: targets of violence in the social networks of people with serious psychiatric disorders. *Journal of Social Psychiatry and Psychiatric Epidemiology*, 33, S95-S101.

Felix, A.; Barber, C.; Lesser, M. (2001) Serving Homeless Paroled Offenders with Mental Illness. *Community Mental Health Report*, May/June.

Fine, E (1988) *Mental Health Services to Jails*, Tennessee Department of Mental Health and Mental Retardation, Nashville, TN.

Goldkamp, JS; Irons-Guynn, S (2000) *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernadino, and Anchorage.* Bureau of Justice Assistance. April, available at: *www.ncjrs.org/pdffiles1/bja/182504.pdf*.

Hea, MA; Laben, JK, Curran, R (1999) *Mental Health Diversion Project Report*, State Justice Institute, Nashville, TN

Janes, C (1993) *Study of Inmate Population of Davidson County Criminal Justice Center*. Vanderbilt University Medical Center, Nashville, TN.

Kessler, RC (1999) A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness, *In Mental Health United States 1999,* Manderscheid, RW and Henderson MJ eds., Rockville, MD, Center for Mental Health Services.

Lewyckyj, I (1999) Mental Health Jail Diversion, Davidson County Office of the Public Defender, Nashville, TN.

Monahan, J; Steadman, H; Silver PS, Applebaum, PC, Robbins, EP; Mulvey, LH; Roth, LH; Grisso, T, Banks, S. (2001) The MacArthur Violence Risk Assessment Study, *Community Mental Health Report*, May/June, 51-63.

Morgan, J (2002) *Prescription Drug Costs in Tennessee*, Tennessee Comptroller of the Treasury, Office of Research, Nashville, TN.

National GAINS Center for People with Co-Occurring Disorders in the Justice System (2000) *Creating Integrated Service Systems for People with Co-Occurring Disorders Diverted from the Criminal Justice System: the King County (Seattle) Experience.* Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System, Summer.

O'Hara, A, Miller, E (2001) Priced Out in 2000: The Crisis Continues. Boston: Technical Assistance Collaborative, June.

Steadman, H., Mulvey, E., Monahan, J., Robbins, P., Appelbaum, P., Grisso, T., Roth, L., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Archives of General Psychiatry, 55, 393-401.

Steadman, H; McCarty, D; & Morrisey, J. (1989) *The Mentally Ill in Jail.* New York: Guildford, p. 5-7.

Teplin, Linda and Karen Abram. (1991) "Co-Occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy." *American Psychologist* 46, no. 10, 1036-45.

Zager, L (1990) *Mental Health Services to Inmates of the Shelby County Jail*.